# Test Criteria: 170.315.b.9 Care Plan

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| **Testing Result** |  |
| Participant and Product-with-version |  |
| Setting (Ambulatory or Inpatient) |  |
| Test Proctor |  |
| Test Date |  |
| Test Result | Pass:  Fail:  No Attempt: |
| Error Description (if applicable) |  |
| Modifications to Product Under Test |  |
| Additional Software Used |  |
| Additional Proctor Notes |  |

### Overview

In this document you will find:

* [Test Data and Test Tools](#_Test_Data_and)
* [Standards Support](#_Demonstrate_Standards_Support)
* [Drummond Test Report (Instructions, Expected Results, Points to Remember)](#_170.315(b)(9)_Enable_a)
* [Test Procedures](#_Test_Procedures)
* [Appendix A: Testing Guide](#_Appendix_A:_Testing)
* [Appendix B: ONC Criteria](#_Appendix_B:_ONC)

### Version of ONC Test Method

1.0

### Scope of Proctoring Sheet

The ONC test method associated with this criterion is the only approved test method for EHR Meaningful Use certification. This Proctoring Sheet is not a replacement test method but a test procedure document for performing the ONC test method and recording the results. Proctoring Sheet describe test data, test criteria and expected results. It is assumed the Health IT developer or Participant under Test is familiar with the associated ONC test method.

# Robustness and Reliability Requirement

To satisfy the module criteria, it is expected that the Product-Under-Test is able to complete the testing requirements reliably, including repeat testing with the same result without error, and with a satisfactory level of robustness. This includes unexpected error messages produced through normal operation, multiple unintended restarts of the application or any other “buggy” facets of the product displayed while testing. These errors are record in the Additional Proctor Notes of the proctor sheet. Lack of reliability and robustness of design will result in failure of the module.

# Test Data and Tools

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| **Test Data Source:** | ONC-Supplied  DG-Supplied:  Developer-Supplied: |
| **Pre-Test Data Setup:**  Using the DG-supplied “170.315.b.9\_Care\_Plan\_TestData” test data sheet, health IT developer pre-loads data for the applicable setting:   * + 1.1 Record Care Plan – Ambulatory; or   + 2.1 Record Care Plan - Inpatient | |
| **Test Data:**  During test event, developer will enter data from “Change Care Plan” section for the applicable setting of the DG-supplied “170.315.b.9\_Care\_Plan\_TestData” test data sheet. This data will be used to generate the CCDA Care Plan as part of test procedure “1.4 Create Care Plan” below.  The following CCDA test documents can be downloaded from the Edge Test Tool (ETT) and will be ‘received’ as part of test procedure “1.5 Receive Care Plan: Positive” below:   * + Inpatient setting: 170.315\_b9\_cp\_inp\_sample\*.xml (All Samples)   + Ambulatory setting: 170.315\_b9\_cp\_amb\_sample\*.xml (All Samples)   The following CCDA test documents can be downloaded from the Edge Test Tool (ETT) and will be ‘received’ as negative test cases as part of test procedure “1.6 Receive Care Plan: Negative” below:   * + NegativeTesting\_CarePlan (All Samples) | |
| **Test Tools:**  Edge Test Tool (ETT) – Message Validators: [C-CDA R2.1 Validator](https://edge.nist.gov/ett/#/validators) | |

# Demonstrate Standards Support

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| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** Implement standards to demonstrate support of the Care Plan document template, including the Health Status Evaluations and Outcomes Section and Interventions Section (V2), in the C-CDA R2 standard. | |

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| **§170.205 Content Exchange Standards – Patient Summary Record** | | |
|  | §170.205(a)(4) | [HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes, Draft Standard for Trial Use Release 2.1](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=408) |

# 170.315(b)(9) Enable a User to Record, Change, Access, Create, and Receive Care Plan

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| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** User records, changes, accesses, creates, and receives care plan information in accordance with the Care Plan document template, including the Health Status Evaluations and Outcomes Section and Interventions Section (V2), specified in the C-CDA R2.1 standard. | |
| **Expected Test Result:**   * Enable a user to record, change, access, create, and receive care plan information in accordance with the Care Plan document template, including the Health Status Evaluations and Outcomes Section and Interventions Section (V2), in the standard specified at §170.205(a)(4). * Health IT module can identify errors in an invalid C-CDA R2.1 Care Plan document and display the recorded errors to the user. | |
| **Points to Remember:**   * The Care Plan document template is distinct from the “Plan of Care Section” in previous versions of the C-CDA * The care plan document template supports broader information about the patient, including education, physical therapy/range of motion, and social interventions not commonly found in other parts of the C-CDA standard and is also distinct from the 'Plan of Treatment Section' in Version 2.1 of the C-CDA. (The Plan of Care Section in C-CDA 1.1 was renamed Plan of Treatment Section in C-CDA 2.0 and 2.1). | |

### Test Procedures

* 1. **Record Care Plan**

**The DG-supplied “170.315.b.9\_Care\_Plan\_TestData” sheet will be used for test procedure sections 1.1 – 1.3 below.**

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|  | User pre-loads data from the “Record Care Plan” section for the applicable setting. User accesses pre-loaded test patient record(s) to verify test data recorded:   * **Patient Name;** * **Goals;** * **Health Concerns;** * **Health Status Evaluations and Outcomes; and** * **Interventions** |

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**1.2 Change Care Plan**

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|  | User changes care plan data within the patient record based on the “Change Care Plan” section for the applicable setting:   * **Patient Name;** * **Goals;** * **Health Concerns;** * **Health Status Evaluations and Outcomes; and** * **Interventions** |

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**1.3 Access Care Plan**

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|  | User accesses the care plan correctly and without omission from the patient’s record according to the data from the “Access Care Plan” section. |

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**1.4 Create Care Plan**

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|  | For each care plan recorded by the health IT module, the user creates care plan document template in the standard adopted at §170.205(a)(4), and includes the Health Status Evaluations and Outcomes Section and Interventions Section (V2) which at a minimum includes the:   * **Patient Name;** * **Goals;** * **Health Concerns;** * **Health Status Evaluations and Outcomes; and** * **Interventions.** |
|  | User submits care plan documents to Proctor for validation. |
|  | Proctor validates care plan document(s) using Edge Test Tool (ETT) [C-CDA R2.1 Validator](https://edge.nist.gov/ett/#/validators) to verify the Health IT Module passes without error in order to confirm that document is conformant to required standard. |
|  | Proctor performs visual inspection of the care plan document(s) to verify:   * Health Status Evaluations and Outcomes Section are included; * Interventions section (v2) is included; * Additional checks for equivalent text for the content of all section level narrative text. |

<INSERT LINK(S) TO VALIDATION REPORT(S)>

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**1.5 Receive Care Plan: Positive**

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|  | Health IT module receives the ONC-supplied care plan documents “**170.315\_b9\_cp\*.xml**” downloaded from ETT Receiver SUT Test Data section for the applicable health care setting, the health IT module will receive these files. All of the care plan (xml) documents for a given setting must be received. |
|  | Proctor verifies health IT module can receive care plan documents formatted in accordance with the standard at §170.205(a)(4) and performs visual inspection to verify:   * Health Status Evaluations and Outcomes Section are included; * Interventions section (v2) is included; and * Care Plan document received is accurate and without omission |

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**1.6 Receive Care Plan: Negative**

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|  | Health IT module receives the ONC-supplied care plan documents located within the “**NegativeTesting\_CarePlan**” folder downloaded from ETT Receiver SUT Test Data section for the applicable setting. ***All*** negative test care plan (xml) documents must be received. |
|  | Proctor performs visual inspection verifying health IT module can successfully identify errors in the C-CDA documents not specified in accordance with the standards adopted at §170.205(a)(4) including:   * “document-templates”; * “section-templates”; * “entry-templates”; * Invalid vocabulary standards; and * Invalid codes |

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# Appendix A: Testing Guide

*This appendix contains more details and background on the testing requirements, including explanation on underlying standards, notable issues and best practice suggestions.*

Rev 01-Mar-2016 Additions

* Consistent with ONC policy, health IT must enable a user to record, change, access, create, and receive information for those sections of the C-CDA Care Plan template that are required, including the “Goals” and “Health Concerns” Sections. These sections could contain patient-expressed information, including patient-expressed goals and health concerns. Because of this, the information contained within the “Goals” and “Health Concerns” Sections of the care plan document could differ from the information contained within those same sections in a transition of care/referral summary document.
* Health IT must enable a user to record, change, access, create, and receive information for the “Health Status Evaluations and Outcomes Section” and “Interventions Section (V2)”. Although these sections are deemed optional in the C-CDA standard, they are required for certification.
* Although a system will need to be able to receive a care plan in accordance with C-CDA Release 2.1, the system is not required to enable a user to reconcile the care plan data.

# Appendix B: ONC Criteria and Standards

*This appendix contains copy of the relevant ONC criteria and standards for this proctor sheet as a reference. In the event of a discrepancy with the ONC Final Rule, the ONC Final Rule takes precedence.*

**§170.315(b)(9) *Care plan.*** Enable a user to record, change, access, create, and receive care plan information in accordance with the Care Plan document template, including the Health Status Evaluations and Outcomes Section and Interventions Section (V2), in the standard specified in § 170.205(a)(4).

**§170.205 Content Exchange Standards – Patient Summary Record.**

**(a)(4) *Standard.*** HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 1—Introductory Material, Release 2.1 and HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 2—Templates and Supporting Material, Release 2.1 (incorporated by reference in § 170.299).

# Change Log

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| Revision | Change Description |
| 01-Nov-2016 | Added reference to DG-supplied b9 test data sheet throughout test data and test procedure sections. |
| 01-Mar-2016 | Initial Release. |
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**About Drummond Group LLC**

Drummond Group LLC is a global software test and certification lab that serves a wide range of vertical industries.  In healthcare, Drummond Group tests and certifies Controlled Substance Ordering Systems (CSOS), Electronic Prescription of Controlled Substances (EPCS) software and processes, and Electronic Health Records (EHRs) – designating the trusted test lab as the only third-party certifier of all three initiatives designed to move the industry toward a digital future. Founded in 1999, and accredited for the Office of the National Coordinator Health IT Certification Program as an Authorized Certification Body (ACB) and an Authorized Test Lab (ATL), Drummond Group continues to build upon its deep experience and expertise necessary to deliver reliable and cost-effective services. For more information, please visit <http://www.drummondgroup.com> or email [ehr@drummondgroup.com](mailto:ehr@drummondgroup.com)

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